The Coalition of Voluntary Mental Health Agencies, Inc.

INFORMATION ALERT

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A non-profit tax-exempt organization representing New York City's community-based mental health sector.

Providers Beware!

Adult Mental Health SNP RFP:

- SCOPE OF THE BENEFIT PACKAGE

A. **Medical Necessity**

An overarching problem with this whole RFP, from a financial standpoint, is the scope of the benefit package. There is simply no ceiling on benefits. The RFP definition of Medical Necessity (§ 3.10.3.5)[1] is very broad. For example, in that definition the

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[1] **3.10.3.5 Definition of Medical Necessity**

"Medically necessary services are any services in the benefit package, as described in Section 3.7 of this RFP, necessary to effectively:

- Screen for and assess the presence and severity of a mental illness condition
- Screen, assess and refer enrollees for physical illness and substance abuse conditions
- Treat, ameliorate, diminish or stabilize symptoms of mental illness, including impairments in functioning
- Prevent, arrest or delay development or progression of a mental illness, or prevent, arrest or delay relapse
- Enable the enrollee to attain or maintain maximum functional capacity in areas of daily living such as work, social relationships and independent living, taking into account both the functional capacity of the enrollee and those functional capacities appropriate for individuals of the same age
- Ensure the enrollee obtains and retains supports in the community to enhance recovery, safety and independence, including linkages to appropriate non-Plan services.

Medically necessary services must:

- Be appropriate to meet the needs of the enrollee in the least restrictive way
- Be appropriate to, and necessary for, addressing the diagnosis and symptoms of the enrollee's mental illness and resulting functional limitations
- Be consistent with standards of good practice for the service delivered based on *practice guidelines* that are approved by the Departments and the City, as required by Section 3.10.5 of this RFP

obligation to "[e]nsure [that] the enrollee obtains and retains supports in the community to enhance recovery, safety and independence" is completely open-ended. There will simply not be adequate funds available to SNP providers to cover all included "medically necessary" services (such as employment and rehab) which would fit under this umbrella.

Although not specifically stated, it is clear that the SNP/Contractor will make the determination of what services are medically necessary, and the Contractor may be overruled by the Departments of Health and Mental Health and the City.[2] The provider of services has no decision making power in this key area.

B. **Unclear scope of covered services – example: vocational services**

The RFP requirements are not only very broad, but are occasionally quite contradictory and unclear as to scope. For example, under **Benefit Package/Covered Services** (§3.7), the Contractor is expected to provide linkages to "**Vocational services**, except for those services described in Appendix H of this RFP," but "will not be responsible for payment for the provision of the services themselves (except to the extent that the Contractor enters into a separate agreement with the City of the Departments for the purchase of such services using non-Medicaid funds)." However, App. H (at H-5) lists "employment supports" under the covered category of support services and gives the example of such support as "job coach works with individual to alleviate issue on job site which jeopardizes his/her employment." Additionally, App. G (at G-3) lists as covered SNP benefits "vocational services" (a rehabilitation service) and "employment supports" (a support service), both being "covered as needed based on medical necessity." This seems to contradict § 3.7.

Note also that the definition of Medical Necessity includes services necessary to effectively "enable the enrollee to attain or maintain maximum functional capacity in areas of daily living such as *work*, social relationships and independent living, taking into account both the functional capacity of the enrollee and those functional capacities appropriate for individuals of the same age."

C. **Referral Obligations; Linkages**

Additionally, under RFP § 3.7 (Benefit Package/Covered Services) the Contractor must provide linkages to the following services:

- Housing

- Not be delivered primarily for the convenience of the provider, contractor or enrollee...."

[2] The Definition of Medical Necessity (§ 3.10.3.5) concludes:

"The Departments and the City reserve the right to review the contractor's determinations with regard to the medical necessity of services, and to require that the contractor provide coverage for services determined by the Departments and the City to be medically necessary, and therefore covered services."

- Transportation
- Direct clinical service to persons other than enrollees
- Alcohol and substance abuse detoxification or treatment including methadone maintenance
- Educational services

Again, these are not covered services (unless otherwise contracted for), but I wonder what guarantee there will be that these services will actually be available to enrollees when needed. And how will these services be funded?

D. **Re: Kendra's Law and Forensic Clients**

Under **Medicaid Covered Court-Ordered Service** (§ 3.7.1), the Contractor must provide, through a participating *or* nonparticipating provider, services ordered by a court. Nonparticipating providers "shall be reimbursed by the Contractor at the Medicaid fee or rate schedule for the court-ordered service." This obligation would seem to apply to services under Kendra's Law. Again, how will the capitation rate stretch to cover these expanded court-ordered services?

Also, under **Special Needs of Forensic Subgroup** (§ 3.7.9, at pages 66-67), the Contractor shall be capable of meeting the needs of this subgroup, including "parolees and individuals with a history of involvement in the criminal justice system." This includes the principle of "*promoting continuity of care for enrollees who become ineligible for Medicaid due to incarceration*." Without presumptive Medicaid eligibility, will Contractors and providers be financially responsible for these non-Medicaid enrollees?

- CONTINUATION OF TREATMENT OBLIGATIONS

<u>Provider obligations continue after a SNP or IPA insolvency or contract termination.</u>
The State will require the following clause in all provider contracts:

"Provider agrees that, except as otherwise required by statute or regulation, *in the event of SNP or IPA insolvency or termination of this contract for any reason, during the period covered by the paid enrollee premium services* pursuant to the subscriber or County SNP contract to an enrollee confined in an inpatient facility on the effective date of insolvency or other event causing termination, or receiving a course of treatment in progress, *shall continue until medically appropriate discharge or transfer, or completion of the course of treatment, whichever first occurs.* For purposes of this clause the term Provider shall include IPA and IPA's contracted providers if this Agreement is between SNP and IPA. This provision shall survive termination of this Agreement." (App. N, at N-17 and N-6; emphasis added). How are providers to be compensated for providing such service?

<u>Ninety-day transitional care for enrollees</u>
Public Health Law § 4403(6)(e) mandates a ninety-day period of "transitional care" for enrollees whose provider has disaffiliated with the plan network. App. N of the RFP states

that "Contractors may also include express provisions [in provider contracts] addressing [this transitional care coverage]... Addressing this enrollee option in provider contracts will help ensure provider awareness of these new provisions." (App. N, at N-6 and N-17) Under RFP § 3.4.3.6.3, to be compensated for this transitional care, providers must agree to:

- Accept reimbursement from the contractor at rates established by the contractor as payment in full. Such rates shall be no more than the level of reimbursement applicable to similar providers within the contractor's network.
- Adhere to the contractor's quality assurance requirements and to provide to the SNP all necessary information related to such services.
- Otherwise adhere to the contractor's policies and procedures, including procedures regarding making referrals, obtaining pre-authorization and developing a treatment plan approved by the contractor.

<u>Guaranteed six-month eligibility period (RFP § 3.4.3.5)</u>
Many SNP enrollees will be guaranteed *a six months' continued SNP eligibility after losing their Medicaid eligibility* – exceptions are loss of eligibility due to a) incarceration, b) moving out of the State, and c) recipient-initiated fraudulent activities in applying for Medicaid. An individual who has lost Medicaid eligibility for more than three months and then regained it will be entitled to a new six-month SNP continuation period; for an eligibility loss of less than three months, there is no such entitlement to a new period. While this continued SNP eligibility period is laudable from a recipient service standpoint, it is an uncertain and possibly heavy financial liability for the Contractor and SNP service providers. (Where did this come from? It does not appear to be set forth in the Partnership Plan.)

- FINANCES, GENERALLY

In addition to the financial concerns detailed above, an overall issue arises from the RFP's general principles of compensation (§ 3.11.1) and Financial Requirements generally (§ 3.11). If a basic principle is to "produce savings over the contract period" and there is in place a methodology for the State to regularly recapture these savings, there will be no opportunity for a SNP Contractor or its providers to retool or add to its system of services to more effectively meet enrollees' needs. This will always be a system of subtraction and contraction, with no expansion possible.

Relevant to this overall concern, I wonder why the HIV SNP RFA is able to allow for equal sharing between the State and the HIV SNP of medical profits as well as medical *losses* (outside a certain corridor) (RFA § 4.4.2.2. Risk-Sharing Outside of the Two Percent Corridor), while the Mental Health SNP RFP provides only for Gain Sharing (RFP § 3.11.9).

- CONTRACT TERMINATION

Is it workable (or fair) for a Contractor to only be able to terminate the contract agreement in cases when it "is unable to provide services *because of a natural disaster or an act of God*" (RFP § 6.2.3; emphasis added)?[3]

[3] The City, in consultation with the Departments, may terminate the contract for a number of reasons, ranging from material breach of the contract to insolvency of the Contractor (RFP § 6.2.1). The Contractor may also terminate, in case of material breach or failure to cure by the City (RFP § 6.2.2). But that's it.